STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396128	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAPLE FARM STATE LICENSE NUMBER: **22720201**	**604 OAK STREET** **AKRON, PA 17501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on June 2, 2023, it was determined that Maple Farm was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0580 SS=D		F 0580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0580 SS=D	Continued from page 1 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Resident 31 was sent out to the hospital following physician assessment on the morning of May 17, 2023. The facility cannot correct the deficiency as it relates to the individual resident. Facility will complete a random audit of current resident medical records to ensure change in condition was appropriately communicated to the physician. Licensed staff will be re-educated on the Notification of Condition Changes Policy and clinical documentation. Facility Director of Nursing or designee will provide SBAR (Situation, Background, Assessment, Recommendation) tool cards to licensed staff to assist in flow of communication to physician. The corrective action will be monitored through random audits of the 24-hour nursing report weekly for 4 weeks and then monthly for 2 months. If any issues are identified during the audit, they will be	Completion Date: **07/21/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0580 SS=D	Continued from page 2 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	corrected and nursing staff will be re-educated. Results of audits will be reported to the Quality Assurance Improvement Committee.	

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F 0580 SS=D	Continued from page 3 Based on a review of the facility's policy, review of the clinical record and hospital records, and staff interviews, it was determined that the facility failed to ensure the physician was appropriately notified of a change in condition for one of the 14 residents reviewed (Resident 92) Findings include: Review of the facility's policy titled "Transcription of Physicians Orders" with an effectivity date of September 1, 2009, revealed that a resident-centric secure conversation will be started by a nurse only if the situation does not need immediate attention by the practitioner. The practitioner will view the message, may review the resident's chart, then respond to the message with acknowledgment, new order, or questions. Review of the nursing progress notes dated May 3, 2023, revealed Resident 92 was admitted to the facility post small bowel resection (Surgery to	F 0580		

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F 0580 SS=D	Continued from page 4 remove part of the small intestine). Review of the physician's notes dated May 10, 2023, revealed resident received exploratory laparotomy in the hospital (surgery to open the abdomen to find the cause of the problems that testing could not diagnose), and a small bowel resection. The resident has an abdominal surgical wound with staples which will be followed by the surgeon. The note revealed that during the May 10 (2023) evaluation, the resident was clear and coherent, reported feeling well, and not having any residual abdominal pain. The resident had been eating and drinking well. Vitals were blood pressure- 134/71 mm; heart rate-69 per min.; respirations 16 per min., and temperature 98.1 Fahrenheit (F). Review of the nursing progress notes dated May 16, 2023, at 7:39 p.m., revealed resident appeared tired and flushed in the face. The resident complained of lower back pain, and the temperature was 100.9 F, as needed Tylenol was administered (medication to	F 0580		

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F 0580 SS=D	Continued from page 5 treat mild pain and fever). Review of the "Secure Conversation" dated May 16, 2023, at 9:02 p.m., documented by the nursing supervisor, Employee E3, revealed a message with a subject of temperature elevation and complaint of back pain. The message revealed that Employee E3 was notified of a resident "not feeling well" with a flushed face, the temperature was 100.9 F with mild lower back pain and medication the nurse administered as needed Tylenol order. The resident's temperature was checked at 8:55 p.m. and found to be 97.9F, with no complaint of discomfort or feeling feverish. Conversation participants include Employee E3, Employee E5, and the Nurse Practitioner. Review of the "Secure Conversation" documentation revealed no response from the practitioner. The clinical records review failed to reveal that a follow-up call/message was sent to the practitioner. Clinical records failed to reveal that the practitioner had received, reviewed, and acknowledged the	F 0580		

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F 0580 SS=D	Continued from page 6 message sent via secure conversation. Interview conducted with licensed nurse Employee E4 on June 1, 2023; revealed she/he was a regular evening shift nurse of Resident 92. Employee E4 reported approximately 7:00 p.m., the resident's temperature was 101 F. The nurse continued to relay that she/he checked the resident's baseline vitals and confirmed that the temperature was elevated from the baseline. Employee E4 confirmed that she/he never received any previous report of elevated temperature for the resident, and this was the first time he/she had a temperature of 101 F while caring for the resident. Employee E4 confirmed that the elevated temperature was a change in condition for the resident. The nurse notified the nursing supervisor of the resident's condition and administered with needed Tylenol for the fever. Employee E4 reported that the nursing supervisor "had reached out to the provider" but was not sure of the mode of notification. Employee E4 reported that it was the facility's protocol to notify the nursing supervisor and they are the one	F 0580		

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F 0580 SS=D	Continued from page 7 who notifies the NP/MD. Employee E4 reported that the incoming shift reported the resident's condition. Review of Resident 92'a May 2023, Medication Administration Record (MAR) revealed Resident 92 was administered with Acetaminophen 500 mg extra strength two tablets (1000mg) on May 16, 2023, at 7:44 p.m. Interview conducted with licensed nurse Employee E5 on June 1, 2023 revealed he/she was the nursing supervisor on May 17, 2023, morning shift. Employee E5 explained that the "Secure Conversation" are messages sent to the nurse practitioner and used for issues like medications. Employee E5 confirmed that for a resident's significant change in condition, the on-call physician should have been called. Employee E5 reported that upon reading the secure conversation indicating that the resident had an elevated temperature the night before and still with an elevated temperature in the morning, the physician who was in the building was	F 0580		

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F 0580 SS=D	Continued from page 8 notified. Review of the physician's notes dated May 17, 2023, at 8:50 a.m., revealed resident developed a fever of 101.5 F last night and was given Tylenol, for some reason the on-call physician was not notified of the fever last night. This morning the resident is weak, has a slight cough, and is having difficulty getting out of bed when he/she was prior independent. Spoke with the physical therapist and nurse and they noticed significant change. Resident appears flushed and warm, heart rate was 120 /min., and his temperature is 101F. The Resident complained of slight back pain today, seemed thirsty, appears dyspneic (short of breath), and has a slight cough with some clear mucus. Review of the nursing progress notes dated May 17, 2023, at 11:23 a.m., revealed resident was assessed by the physician and continued with a fever of 100.1 F, the physician ordered to send the resident to the ER (Emergency Room) for evaluation and treatment, 911 was called, the wife was notified.	F 0580		

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F 0580 SS=D	Continued from page 9 Review of the hospital records and discharge summary revealed resident was admitted to the hospital on May 17, 2023, with admitting diagnosis of Sepsis - (The body's extreme reaction to an infection, without prompt treatment can lead to organ failure, tissue damage, and death). The problem list revealed sepsis end-organ dysfunction suspected secondary to residual fluid collections, and peritonitis (inflammation of the membrane lining of the abdominal wall and covering abdominal organs) after recent bowel perforation. Possibly UTI (urinary tract infection). Followed by an Infectious Disease doctor and treated with antibiotics. Interview conducted with the Director of Nursing (DON) on June 2, 2023, at 11:00 a.m. confirmed there was no documented evidence the on-call physician was notified of the resident's elevated temperature on the night of May 16, 2023. Clinical records review revealed a "Secure Conversation" was sent to the NP (Nurse	F 0580		

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F 0580 SS=D	Continued from page 10 Practitioner) instead calling the on-call physician on the night of June 16, 2023, for Resident 92's complaint of "not feeling well", back pain, and elevated temperature. The facility failed to ensure Resident 92's change in condition, elevated temperature was appropriately communicated with the physician. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c) Resident Care Policies	F 0580		

Certified End Page

MAPLE FARM

STATE LICENSE NUMBER: 22720201

SURVEY EXIT DATE: 06/02/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY